

# City of Newton Comparison Chart of Medicare Supplement Plans

Coverage	Tufts Medicare Preferred For Retirees Living in Massachusetts Only	Tufts Medicare Complement Plan MCP	Medicare HMO Blue For Retirees Living in Massachusetts Only
Monthly Premium	\$53.40	\$91.77	\$60.17
Rates Effective Until	December 31, 2016	June 30, 2016	December 31, 2016
Inpatient Services			
Hospital	100% Coverage after \$300 Deductible per Calendar Year	100% Coverage	\$150 per day Copay \$750 Maximum per admission
Skilled Nursing	Covered in Full for 100 Days in a benefit period	Covered in Full for 100 Days in a benefit period	For each benefit period, you pay: Days 1-20: \$40 co-pay per day Days 21-44: \$100 co-pay per day Days 45-100: \$0 co-pay per day
Mental Health & Substance Abuse Care	Covered in Full in a Network Psychiatric Hospital. 190 Day Lifetime Limit. 90 days covered for inpatient hospital stay. After limit is reached, 60 lifetime reserve days allowed.	Covered in Full. 190 day Lifetime Limit. After limit is reached, 60 Days per year in a Psychiatric Hospital and 30 days per year in a Substance Abuse Facility.	\$150 per day (\$750 maximum per admission). 190 day Lifetime Limit
Out Patient Services			
Primary Care Physician Office Visits	\$10 Co-payment/ \$0 for annual physical	\$10 Co-payment/\$0 for annual physical	\$15 Co-payment/\$0 for annual physical
Specialist Physician Office Visits	\$15 Co-payment	\$10 Co-payment	\$35 Co-payment
Emergency Room	\$50 Co-payment	\$0 Co-payment	\$75 Co-payment
Outpatient Services/Surgery	\$50 per day	Covered in full	\$150 per visit
Outpatient Rehab Services	\$15 copay for Medicare covered therapies	\$10 Co-payment	\$15 co-payment
Prescriptions Co-Pay 30 Day Tier 1 Tier 2 Tier 3	\$10 / \$25 / \$50	\$10 / \$20 / \$35	\$10 / \$25 / \$45
Prescriptions Co-Pay 90 Day Tier 1 Tier 2 Tier 3	90 Day Mail Order \$20 / \$50 / \$100	90 Day Mail Order \$20 / \$40 / \$70	90 Day Mail Order \$20 / \$50 / \$90
Prescriptions Co-Pay Maximum Tier 1 Tier 2 Tier 3	After co-pays of \$4,700 co-pay are reduced to the greater of 5% or \$2.65 generic or \$6.60 for Brand Name Drugs	After co-pays of \$500 per Plan Year, your co-pays reduced to \$0, July 1-June 30	After co-pays of \$4,850 co-pay are reduced to the greater of 5% or \$2.95 generic or \$7.40 for Brand Name Drugs
Dental	Not Covered	Not Covered	One cleaning and one set of Bitewing X-rays every six months \$35 Per visit
Hearing Aids	Up to \$500 Allowed for Purchase or Repair every three years	Not Covered	\$400 Allowed for Purchase or Repair every three years
Routine Eye Exam	\$15 Co-payment	Not Covered	\$35 Co-payment
Eyewear	\$150 Toward eyeglasses or contacts each year in network, or \$90 out of network	Not Covered, discounts available	\$150 once every two years
Ambulance	\$50 per Day	100% for each Medicare approved ambulance service	Covered in Full if Admitted
Chiropractor	\$15 Co-payment	\$10 Co-payment	\$20 Co-payment
Fitness Benefit	\$150 Fitness Reimbursement/ \$150 Weight Management Reimbursement	Not Covered	\$150 Fitness Reimbursement/ \$150 Weight Management Reimbursement